epiminder

FY26 Investor Presentation

Epiminder Limited (ASX:**EPI**)

30 July 2026

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AN EXPERIENCED LEADERSHIP TEAM

Dr Rohan Hoare

Chief Executive Officer

PhD in Physics (Harvard). 25+ years in medical devices, with senior leadership roles at LivaNova, Cyberonics, St. Jude Medical and EndoStim.

Mark McLellan

CFO and Company Secretary

30+ years in finance, including CFO roles at ASX-listed Beamtree Holdings and Rhipe Limited. Previously at RBS, EY and PwC in Australia and the UK.

Dr John Heasman

Chief Operating Officer

PhD, University of Sydney. Nearly 18 years in engineering and technology leadership at Cochlear before joining Epiminder to lead early trials.

Prof Mark Cook, AO

Chief Medical Officer

World-renowned neurologist and Epiminder founder (2018). Awarded the Order of Australia (2023) for service to epilepsy medicine and research.

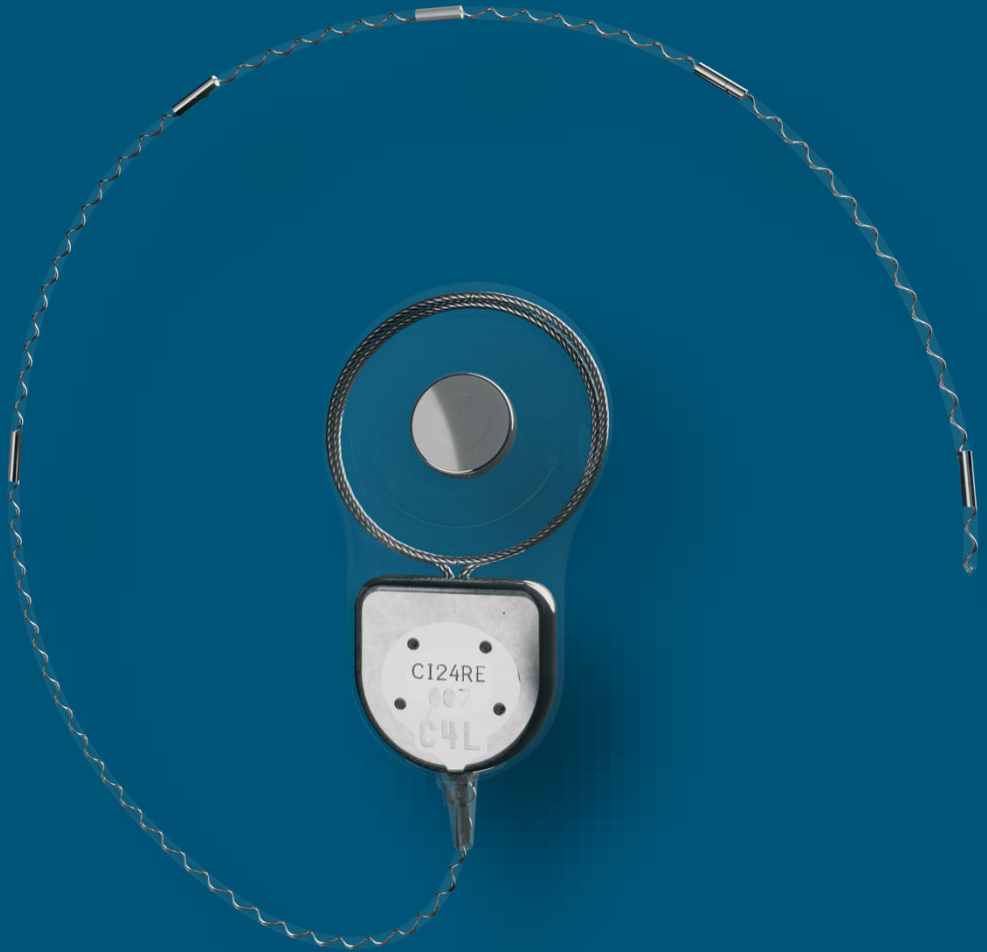
Epiminder is developing a new standard in long-term brain monitoring for people living with drug-resistant epilepsy.

- The Company's FDA-authorised Minder® System is designed for continuous, objective EEG monitoring over months and years, helping physicians better understand seizure activity and make more informed treatment decisions.
- Minder addresses a critical gap in epilepsy care by providing reliable long-term data beyond the limits of short-term EEG monitoring and patient diaries.
- Advancing Minder toward commercialisation through the DETECT study and next-generation device development.

First in Class FDA authorised technology

3 years Continuous monitoring label
The longest of any sub-scalp EEG system

INVESTMENT CASE



INVESTMENT HIGHLIGHTS

Targeting a **major unmet need** in drug-resistant epilepsy

Large underserved market

~1.1 million[1] US adults have drug-resistant epilepsy and lack reliable long-term seizure monitoring

Reimbursement pathway progressing

Coding & Medicare payment established; DETECT study generating clinical and reimbursement evidence for US payer adoption

First-in-class FDA- cleared technology

Minder is the first sub-scalp EEG system approved for monitoring for up to three years

Next-generation device progressing

Lower-profile device progressing toward design validation and commercial readiness

Demonstrated clinical value

Continuous objective EEG data supports better diagnosis and treatment optimisation and patient management[2]

Funded to key milestones

Cash reserves expected to support commercialisation programs well into CY2028 with no debt

Note(s): (1) F&S Market Report; (2) Halliday et al. The UMPIRE study: A first-in-human multicenter trial of bilateral subscalp monitoring for epileptic seizure detection. Epilepsia. 2025 May 30. doi: 10.1111/epi.18458;

INVESTMENT HIGHLIGHTS

FY26 AND FY27YTD HIGHLIGHTS

01

DETECT momentum

50

patients enrolled

20

US sites activated

02

Next-generation Minder

~200 devices manufactured and in testing

Design completion on track for **H1 CY2027**

FDA clearance targeted for **H2 CY2027**

03

Reimbursement progress

2026 Medicare payment to hospital **US$27,700**
2027 preliminary ruling **US$31,600**

Additional TPT payment opportunity

04

Strong financial position

A$75.8m cash

Strong funding position going into FY27

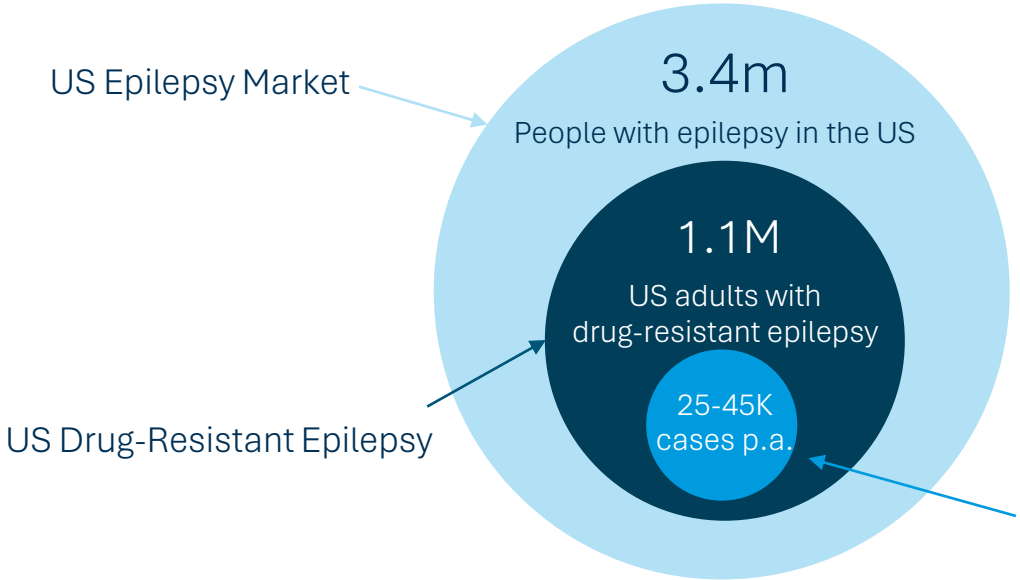
Expected to fund operations **well into CY2028**

MARKET NEED AND OPPORTUNITY

MARKET OPPORTUNITY

Target Market

An initial revenue opportunity of up to US$1.1 billion annually[1]



~25,000-45,000 inconclusive EMU (epilepsy monitoring unit) patient assessments each year

× ~US$25k Minder price = Up to ~US$1.1B p.a. initial US target market[1]

Source: Frost & Sullivan Market Report. [1] Initial target market ≈ ~25,000–45,000 inconclusive EMU-based EEG assessments p.a. for DRE patients (≈30–50% of ~85k annual EMU EEGs) × indicative ~US$25,000 Minder® price..

MARKET OPPORTUNITY

Current monitoring methods provide an incomplete picture

Patient diaries remain the only current option for long-term monitoring, but they are highly inaccurate [1]:

Seizures are often missed

Seizures may be random, infrequent or unrecognised by the patient.

Patient diaries are unreliable

Self-reported seizure records are subjective and frequently inaccurate (~15% accuracy).

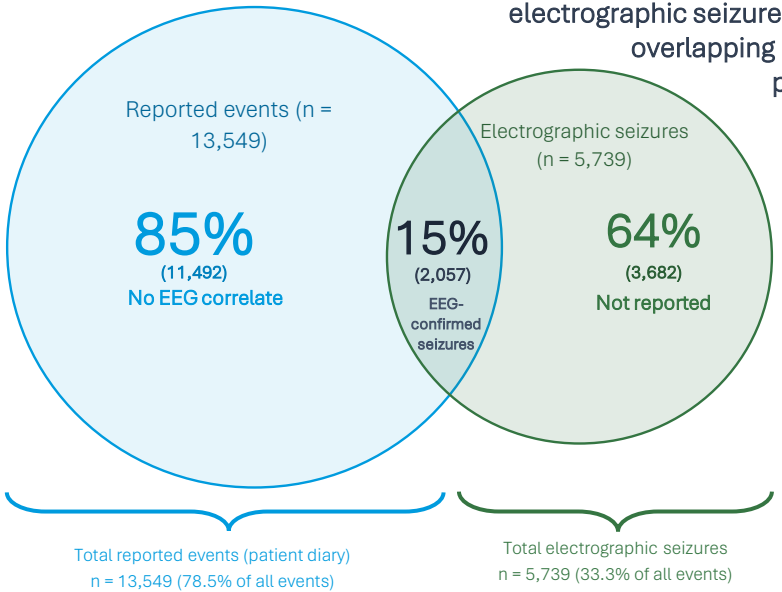
Short-term EEG is limited

Inpatient monitoring is expensive and disruptive, only cover a short period, with 30–50% of assessments inconclusive.

Clinical decisions rely on incomplete data

Physicians may need to diagnose and adjust treatment without objective long-term information.

Reported events and electrographic seizures represent overlapping but distinct populations



(1) Epilepsia, June 9 ,2026 "When seizure counts are not seizures: Measurement error and its implications for epilepsy management and driving policy " https://doi.org/10.1002/epi.70337

OUR SOLUTION

Long-term EEG data to support better treatment decisions

1 Capture missed events

Records seizure activity that short-term monitoring may not capture

2 Generate objective long-term data

Provides continuous EEG data over months and years during patient's daily life

3 Understand seizure burden

Helps physicians assess seizure frequency and patterns more accurately

4 Support better clinical decisions

Informs diagnosis, treatment optimisation and patient management

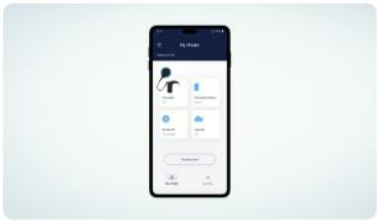
FDA cleared

For adults aged 18–75 with drug-resistant epilepsy.

Positioned to become a new standard

Minder is positioned to become the standard of care for long-term monitoring in this population.

An integrated system for long-term EEG monitoring



Implant

Sub-scalp electrode and telemetry unit continuously record and transmit EEG data.

Wearable

Powers the implant, receives EEG data from the implant and transfers it to the Minder app.

App

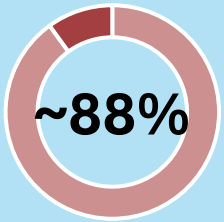
Transfers EEG data securely to the cloud and supports patient diary entries.

Cloud

Enables healthcare professionals to access and review patient data remotely.

Minder has demonstrated actionable clinical insight

UMPIRE clinical study[1]



of patients received meaningful and actionable clinical insight

Examples of clinical impact

- ✓ Surgery avoided after long-term monitoring clarified seizure activity
- ✓ Medication withdrawn after objective evidence showed no ongoing seizures
- ✓ Patient progressed to evaluation for surgical resection
- ✓ Cardiac condition identified and treated, enabling medication reduction

Clinician feedback

> The [Minder] device will **transform epilepsy.**
> – Epileptologist, Stanford

> **Absolutely** this could be useful for diagnostic monitoring when no events are captured in the EMU.
> – Epileptologist, Colorado

> I think that [Minder] is **the future of epilepsy monitoring.**
> – Neurosurgeon, California

Note(s): (1) Epiminder UMPIRE (s**U**bscalp **M**onitoring e**PI**leptic Seizu**RE**s), Australian-based study with 26 patients

CLINICAL VALIDATION AND COMMERCIALISATION

DETECT STUDY

Building the evidence base for reimbursement and commercial adoption

Study Design

Type	Prospective, randomised, controlled, blinded, multi-centre
Sites	Up to 25 US clinical sites, 20 now activated
Enrolment	Up to 210 participants
Follow-up	Six-month primary follow-up period
Primary Endpoint	Proportion achieving an actionable clinical event
Current Status	50th patient enrolled; site activation ongoing

Purpose

Designed to demonstrate the cost-effectiveness and clinical value of Minder in US clinical practice to support payer adoption.

Target Enrolment Completion

H1 CY2027

DETECT STUDY

Accelerating enrolment ahead of original forecast

20 Sites

Perelman School of Medicine, University of Pennsylvania

Washington University in St. Louis, School of Medicine

Mayo Clinic x3

Stanford Medicine

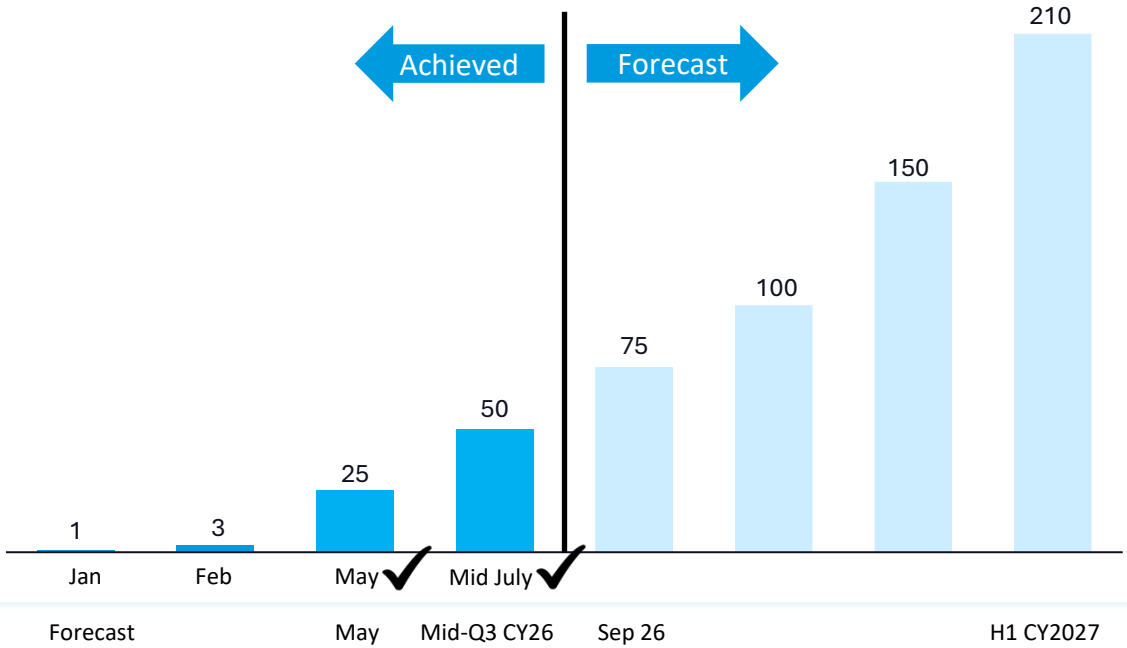
Duke Medicine

Beth Israel Deaconess Medical Center, Harvard Medical School Teaching Hospital

Yale University School of Medicine

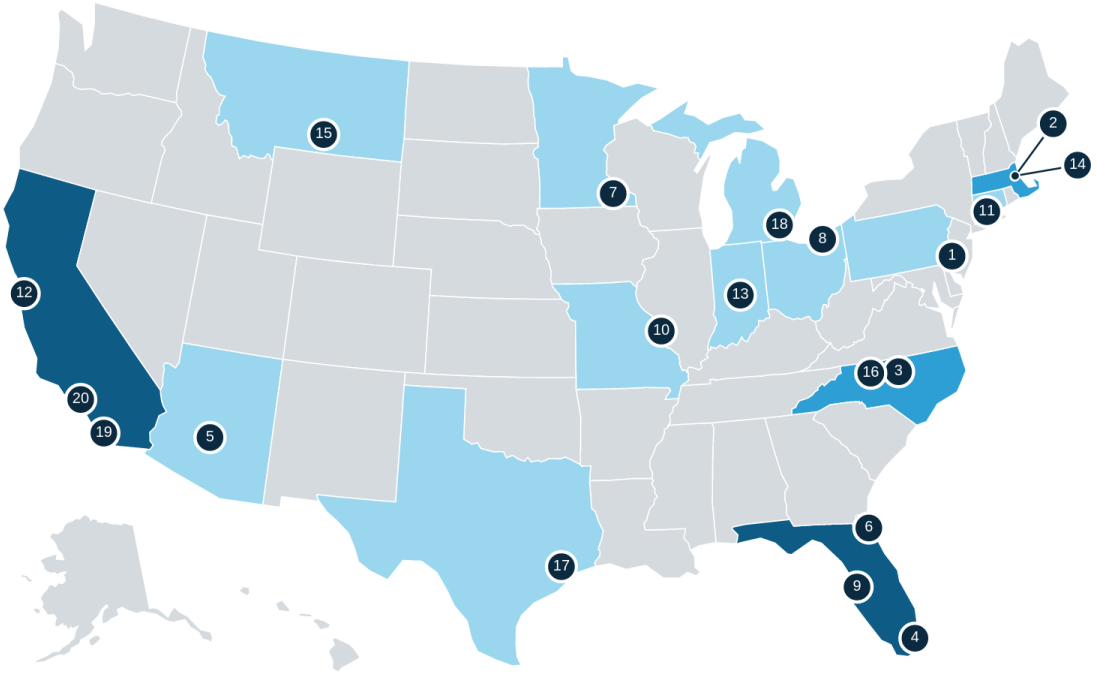
+ 11 more

Forecast Enrolment Profile



DETECT STUDY

Study Sites across the US, ~7% of US CEC (1)



Participating Sites

1. University of Pennsylvania
2. Beth Israel Deaconess Medical Centre
3. Duke University
4. Nicklaus Children's Hospital
5. Mayo Clinic – Arizona
6. Mayo Clinic – Jacksonville
7. Mayo Clinic – Rochester
8. UH Cleveland
9. USF Health
10. Washington University
11. Yale
12. Stanford
13. Indiana University Health
14. Massachusetts General Hospital
15. Billings Clinic
16. Wake Forest University
17. UT Houston
18. University of Michigan
19. UC San Diego
20. UC Irvine

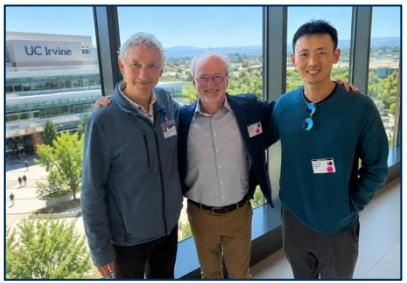
Note(s): (1) Comprehensive Epilepsy Centres

DETECT STUDY

Strong clinical engagement – recent US tour by CMO

Beth Israel Deaconess

Duke University



UC Irvine

Mayo Clinic

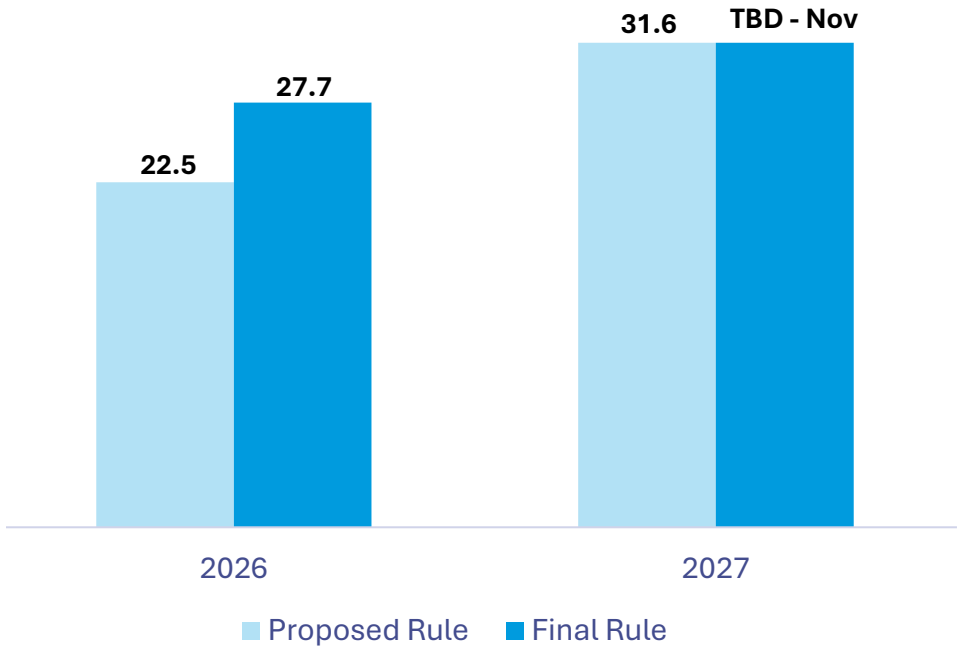
Washington University

KEY TAKEAWAYS

- 10 institutions, more than 100 neurologists engaged in June and July
- Strong and growing interest in Minder, particularly for inconclusive diagnoses
- Clinicians are identifying potential applications beyond the initial target population
- Very positive reception and interest in broader future applications

REIMBURSEMENT UPDATE

Preliminary CY2027 Medicare reimbursement increase supports target US pricing



- Favourable direction in US hospital reimbursement
- Supports targeted Minder System pricing
- CY2027 Final Rule expected in November
- Potential additional payment remains available through Transitional Pass-Through (TPT)

CPT Code 0956T/APC 5117, sub-scalp implantation of an electrode array, receiver and telemetry unit for continuous EEG monitoring in Hospitals.

NEXT-GENERATION DEVICE

On track for H1 CY2027 design completion

Approximately 200 next generation devices have now been manufactured for:

- Biocompatibility testing
- Functional testing

KEY IMPROVEMENTS

- Slimmer telemetry unit to support easier implantation
- Advanced communications and data storage
- Extended battery life
- Lower cost of goods

Growing Long term EEG datasets key to future AI and analytics

November 25, 2024

Epiminder Announces 5-Year Milestone of Long-Term Continuous EEG Monitoring Implant

The longest continuous EEG monitoring device implanted in human

Melbourne, Australia – November 24, 2024 – Epi-Minder Pty Ltd, a m
on the development and commercialization of a sub-scalp Continuou
Monitoring device, Minder®, announced a significant milestone in its
program. As part of the UMPIRE study (**S U** b-scalp **M** onitoring of e **P**
clinical trial in Australia, the Minder device has recorded continuous E
participant. To date, this is the longest continuous EEG recording eve
important milestone in the evolving paradigm of EEG monitoring for
could open a path to seizure freedom.

Rohan Hoare, Chief Executive Officer of Epiminder, stated: "Our inve
device is proving to clinicians in the field of neurology that long term,
becoming a reality. Patients with drug resistant epilepsy manage a ve
freedom and this is often the result of not having objective long term
treating neurologist to make the best informed clinical decisions. The
holds the promise of delivering actionable insights to clinicians and p
control and, for some, achieve seizure freedom."

About epilepsy

frontiers in Neurology

ORIGINAL RESEARCH
published: 23 August 2021
doi: 10.3389/fneur.2021.713794

Seizure Forecasting Using a Novel Sub-Scalp Ultra-Long Term EEG Monitoring System

Rachel E. Stirling[1,2†], Matias I. Maturana[1,3†], Philippa J. Karoly[1,2], Ewan S. Nurse[1,3], Kate McCutcheon[1], David B. Grayden[2,3], Steven G. Ringo[4], John M. Heasman[4,5], Rohan J. Hoare[4], Alan Lai[3,6], Wendyl D'Souza[3,6], Udaya Seneviratne[3,7,8], Linda Seiderer[4], Karen J. McLean[4,6], Kristian J. Bulluss[3,6], Michael Murphy[3,6], Benjamin H. Brinkmann[9], Mark P. Richardson[10], Dean R. Freestone[1] and Mark J. Cook[1,2,3,4]*

[1] Seer Medical Pty Ltd, Melbourne, VIC, Australia, [2] Department of Biomedical Engineering, The University of Melbourne, Melbourne, VIC, Australia, [3] Department of Medicine at St. Vincent's Hospital Melbourne, The University of Melbourne, Fitzroy, VIC, Australia, [4] Epi-Minder Pty. Ltd., Melbourne, VIC, Australia, [5] Cochlear Limited, Sydney, NSW, Australia, [6] Department of Neuroscience, St. Vincent's Hospital Melbourne, Fitzroy, VIC, Australia, [7] Department of Neuroscience, Monash Medical Centre, Melbourne, VIC, Australia, [8] Department of Medicine, School of Clinical Sciences at Monash Health, Monash University, Melbourne, VIC, Australia, [9] Bioelectronics Neurophysiology and Engineering Lab, Department of Neurology, Mayo Clinic, Rochester, MN, United States, [10] School of Neuroscience, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, United Kingdom

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[†]These authors share first authorship

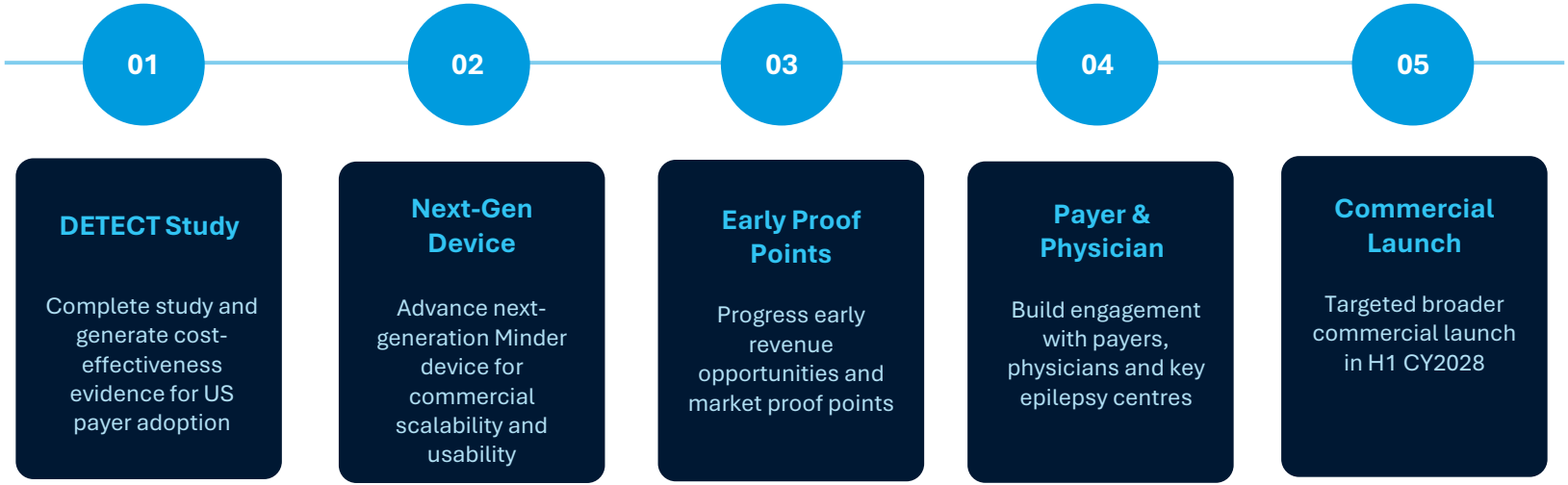
Specialty section:
This article was submitted to Epilepsy, a section of the journal

Accurate identification of seizure activity, both clinical and subclinical, has important implications in the management of epilepsy. Accurate recognition of seizure activity is essential for diagnostic, management and forecasting purposes, but patient-reported seizures have been shown to be unreliable. Earlier work has revealed accurate capture of electrographic seizures and forecasting is possible with an implantable intracranial device, but less invasive electroencephalography (EEG) recording systems would be optimal. Here, we present preliminary results of seizure detection and forecasting with a minimally invasive sub-scalp device that continuously records EEG. Five participants with refractory epilepsy who experience at least two clinically identifiable seizures monthly have been implanted with sub-scalp devices (Minder®), providing two channels of data from both hemispheres of the brain. Data is continuously captured via a behind-the-ear system, which also powers the device, and transferred wirelessly to a

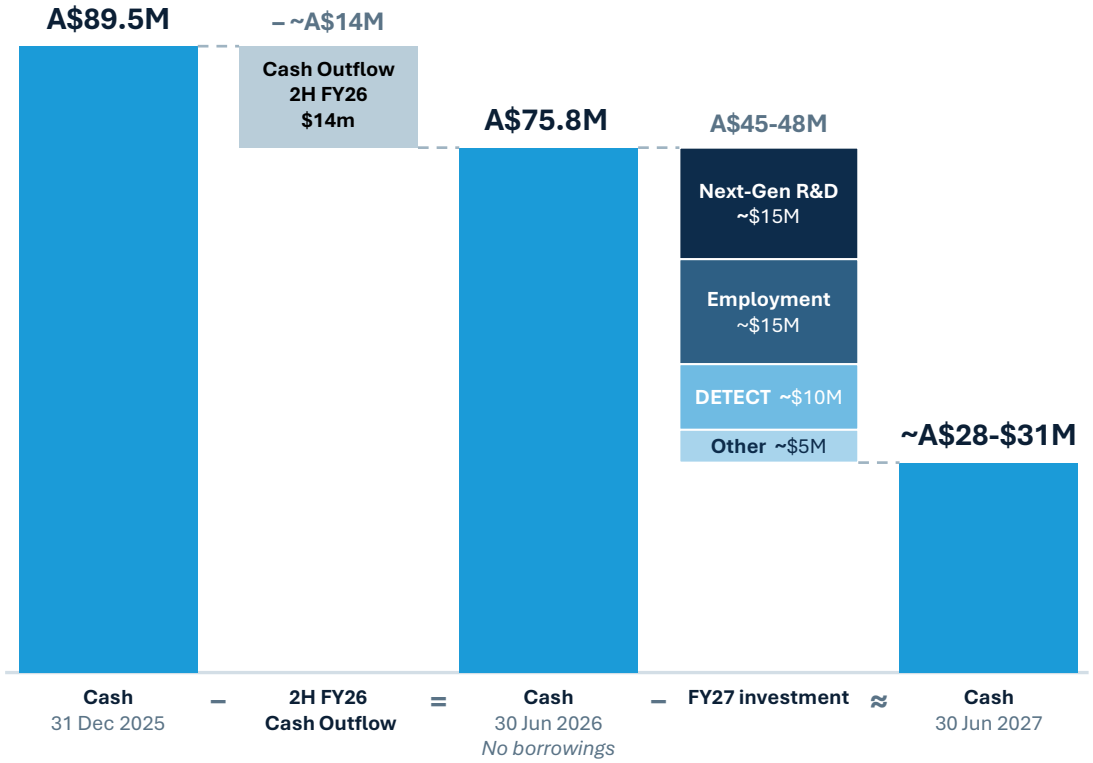
- Longest continuous EEG dataset
- Growing volume of longitudinal patient data
- Algorithmic and AI tools in development
- Potential future applications in seizure forecasting
- Potential opportunities to monetise – pharma, forecasting

COMMERCIALISATION PATHWAY

Epiminder intends to undertake a phased commercial rollout through leading US epilepsy centres ahead of a broader commercial launch expected in H1 CY2028



Funded to execute key value-driving milestones



Funded well into CY2028

- A$75.8 million cash at 30 June 2026, with no borrowings
- FY27 cash outflow expected to be A$45–48 million, reflecting peak investment in DETECT and next-generation development
- DETECT and next-generation development costs are expected to reduce materially from FY28
- Cash resources exclude any R&D tax incentive for FY27

CORPRATE OUTLOOK

Clear milestones over the next 18 months

01

DETECT Study

- Complete enrolment of 210 patients by H1 CY2027
- Continue engagement with participating US clinical sites
- Generate clinical and reimbursement evidence

02

Next-generation Minder

- Complete device development in H1 CY2027
- Target FDA clearance: H2 CY2027
- Prepare for scalable manufacturing commencing H1 2028

03

Commercial Readiness

- Progress early revenue opportunities
- Build payer and physician engagement
- Medicare CY2027 Final Rule on payment
- Prepare for broader commercial launch H1 CY2028

04

Financial Outlook

- Expected FY27 cash outflow of ~$45m to $48m
- Cash usage driven by DETECT volumes and next-gen development
- DETECT and next-gen costs to reduce from FY28
- Sufficient cash reserves to complete DETECT and next gen and fund commercialisation well into CY2028

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Appendix

PROFIT & LOSS (UNAUDITED)

$m	1H FY26	2H FY26	FY26	FY25
Interest Income	**0.4**	**1.7**	**2.1**	**0.4**
Employment Expenses	(4.3)	(5.5)	(9.8)	(6.9)
DETECT Costs	(0.5)	(5.1)	(5.6)	(0.8)
R&D Costs (G1 + G0)	(4.9)	(6.8)	(11.7)	(11.3)
Other Expenses	(1.6)	(2.6)	(4.1)	(4.4)
Operating expenses	**(11.3)**	**(19.9)**	**(31.2)**	**(23.3)**
Share Based Payment Expenses	(3.4)	(2.9)	(6.3)	(2.0)
Depreciation	(0.0)	(0.0)	(0.0)	(0.1)
Impairment Loss	-	-	-	(3.3)
FX gain or loss	(0.1)	0.0	(0.0)	(0.0)
Other (including IPO Costs)	(2.2)	-	(2.2)	(1.5)
Manufacturing Shares awarded to Cochlear	(4.0)	-	(4.0)	-
Non-operating, Non Cash Expenses	**(9.7)**	**(2.8)**	**(12.5)**	**(6.9)**
Total Expenses	(21.0)	(22.8)	(43.7)	(30.2)
EBIT	**(21.0)**	**(22.8)**	**(43.7)**	**(30.2)**
Interest Expense	(1.2)	(0.0)	(1.2)	(1.9)
Net Income	**(21.7)**	**(21.1)**	**(42.8)**	**(31.7)**

- 1H FY26 incurred lower operating expenses in the run up to capital raising in Dec 2025.
- Non operating expenses high in 1H FY26 driven by IPO related charges
- 2H FY26 operating expenses increased driven by investment in DETECT and next generation device

Note: Amounts have been rounded to the nearest $0.1m

BALANCE SHEET

$m	FY26	FY25
Cash and Cash Equivalents	75.8	8.9
Prepayments, GST receivable	1.7	0.5
Current Assets	**77.5**	**9.4**
Fixed Assets	0.1	0.1
Intangible Assets	13.2	13.2
Non Current Assets	**13.2**	**13.2**
Total Assets	**90.7**	**22.6**
Trade and other payables	6.0	18.9
Employee Benefits	0.9	0.6
Borrowings	-	8.4
Current Liabilities	**6.9**	**27.9**
Debenture Notes	-	48.0
Accruals & Provisions	1.5	0.1
Non Current Liabilities	**1.5**	**48.1**
Total Liabilities	**8.4**	**76.0**
NET ASSETS	**82.3**	**(53.4)**
Share Capital	209.1	37.2
Retained Earnings	(141.0)	(98.3)
Options Reserve	14.2	7.7
Total Equity	**82.3**	**(53.4)**

- Balance sheet and capital position significantly strengthened because of IPO capital raise.
- ~$76m of cash at 30 June 2026 with no debt

CASH FLOW STATEMENT

$m	1H FY26	2H FY26	FY26	FY25
Interest Received	0.4	1.1	1.5	0.4
DETECT Costs	(0.3)	(2.0)	(2.3)	(0.8)
G1 Costs	(4.9)	(6.4)	(11.2)	(10.3)
Staff Costs	(4.3)	(4.4)	(8.8)	(6.5)
Other Costs	(4.5)	(2.2)	(6.7)	(5.8)
Operating Activities excluding ATO Refund	**(13.6)**	**(13.9)**	**(27.5)**	**(22.9)**
R&D Rebate / ATO Refund	(15.8)	-	(15.8)	5.9
Operating Activities	**(29.4)**	**(13.9)**	**(43.3)**	**(17.0)**
Other cash items from financing activities	110.0	(0.0)	110.0	14.6
Net Cash Flow	**80.6**	**(13.9)**	**66.7**	**(2.4)**
Cash and cash equivalents at beginning of period	8.9	89.5	**8.9**	11.3
Net change in cash for period	80.6	(13.9)	**66.7**	(2.4)
Effect of exchange rate changes on cash	0.0	0.2	**0.3**	(0.0)
Cash and cash equivalents at end of period	**89.5**	**75.8**	**75.8**	**8.9**

- Operating cash flows in 2H FY26 of ~$14.0m lower than original $20m guidance due to slow invoicing for DETECT.
- Lower cash usage in 2H FY26 is a timing difference and will be unwound in FY27.
- 1H FY27 cash usage expected to be ~$22m to $25m.